Name _____ **Birthdate** _____

Address _____ **City** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____

Who is your primary care physician? _____

Do you have any limitations with any of the following?

Vision ☐ Yes ☐ No **Hearing** ☐ Yes ☐ No **Mobility** ☐ Yes ☐ No **Confusion** ☐ Yes ☐ No

If yes, please describe: _____

_____

Are you on oxygen? ☐ Yes ☐ No **Do you have Lifeline?** ☐ Yes ☐ No **Do you smoke?** ☐ Yes ☐ No

Do you have pets? ☐ Yes ☐ No **If so, please list:** _____

Diet: ☐ General ☐ Heart Healthy ☐ Controlled Carb ☐ Renal ☐ Bland ☐ Gluten-Free ☐ Lactose Intolerant

Diet modifications needed: ☐ Mechanical (cut up) ☐ Ground ☐ Pureed

Do you want to receive 1% Milk with your meals? ☐ Yes ☐ No **Do you want fish meals?** ☐ Yes ☐ No

How many meals do you want each week? _____ **Have you received Meals On Wheels before?** ☐ Yes ☐ No

Emergency Contact #1 (someone local)

Name _____ **Relationship to you** _____

Address _____ **City** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____

Work Phone _____ **Email** _____

Emergency Contact #2

Name _____ **Relationship to you** _____

Address _____ **City** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____

Work Phone _____ **Email** _____

Payment Method

☐ Client/Family pay ☐ Request a referral for help paying for meals

☐ SNAP Payments ☐ Other_____

Fresh Meals On Wheels